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	445017	A. BUILDING _____ B. WING _____	C 11/17/2020

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ASBURY PLACE AT MARYVILLE	2648 SEVIERVILLE RD MARYVILLE, TN 37804

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F 000	INITIAL COMMENTS Investigation of complaints #TN00050957, #TN00051271, #TN00052248, #TN00052378 and a COVID-19 Focused Infection Control Survey was conducted on 11/9/2020-11/17/2020 at Asbury Place at Maryville. A deficiency was cited in relation to complaint #TN00052378 under 42 CFR PART 483, Standards for Long-Term Care Facilities.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after	F 622		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and

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F 622	Continued From page 2 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, medical record review, and interview the facility failed to ensure a physician documented the specific resident needs the nursing home facility could not meet as well as the specific services the receiving facility could provide to meet the needs of 1 transferred/discharged resident (Resident #1) of 4 residents reviewed for admission, transfer, and discharge requirements. The findings included: Review of the Facility policy titled, "Transfer/ Discharge Policy", revised 9/2019, showed, "...Residents will remain at the facility and not be transferred or discharged unless: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...When a resident does need to be	F 622		

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transferred or discharged it will be documented in the resident's medical record...Documentation incudes [includes]...The basis for the transfer and if needs can't be met in the facility and that they can be met in the receiving facility...The physician statement stating a transfer or discharge is necessary and the reasons for such..."

Review of the medical record revealed Resident #1 was admitted to the facility on 7/23/2019 and discharged from the facility on 3/23/2020 with diagnoses including Alzheimer's Disease, Dementia with Behavioral Disturbance, Anxiety Disorder, and Heart Failure.

Review of Resident #1's care plan with an effective date of 7/24/2019- present (current) revealed the resident was care planned for exhibiting behaviors of crawling out of bed onto mats often, risk for psychosocial changes related to temporary restriction of visitors, attention seeking, impulsive behaviors, and antipsychotic and antidepressant medication use.

Review of Resident #1's Quarterly Minimum Data Set (MDS) dated 12/5/2019 showed Resident #1 was severely cognitively impaired and exhibited no behaviors and no psychosis.

Review of Resident #1's Clinical Notes Report dated 2/7/2020 showed, "...Resident observed multiple times exit-seeking...Resident attempting to get down the stairs at the end of the hall...Pushing and beating on the door handle...Resident very agitated unable to be redirected...Resident stating she wants to go home...Social Services notified...NP [Nurse Practitioner] seen resident and assisting with behaviors...Resident sent to Geripsych [Geri

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psych] for exit seeking behaviors and increase agitation...Banging on doors and not able to be redirected...Staff and daughter had to sit with resident until resident left facility at approximately 4 pm..."

Review of Resident #1's Clinical Notes Report dated 3/12/2020 showed, "...Resident exhibiting increased agitation and combativeness with staff...all safety measures in place..."

Review of Resident #1's Clinical Notes Report dated 3/13/2020 showed, "...resident became agitated and combative with staff stating she was getting out of here one way or another...resident clawed this nurses [nurse's] arm with nails, resident requiring one on one care..."

Review of Resident #1's Clinical Notes Report dated 3/14/2020 at 6:34 AM, showed "...resident cont [continue] screaming for another 1.5 hrs [hours] and yelling with combative episodes towards this nurse and staff...staff at side..."

Review of Resident #1's Clinical Notes Report dated 3/14/2020 at 2:36 PM, showed, "...A call was placed to...NP [Nurse Practitioner] and a verbal order was received to send to [name of facility] geri-psych for eval [evaluation]..."

Review of Resident #1's Clinical Notes Report dated 3/14/2020 at 4:00 PM, showed "...resident is approved for inpatient geri-psych at this time... [emergency transport company name] contacted for transport..."

Review of Resident #1's Physician Telephone Orders dated 3/14/2020 showed the resident was sent to a Geri-Psych facility for evaluation and

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treatment.

Review of a facility typed note undated showed, "...Admissions coordinator spoke with resident's daughter...via [by] phone on 3/23/2020 to inform her that we would not be able to meet her mother's needs at our facility any longer..."

Review of Resident #1's Physician Discharge Summary dated 4/6/2020 revealed, "...Discharge 3/23/2020...Transferred HOSP [hospital]...Discharge Summary...Dementia with behavioral Disturbance...Discharge to geri-psych facility for acute E/M [evaluation/management]..."

Review of Resident #1's medical record revealed no documentation by the Physician or Nurse Practitioner related to the specific resident needs the nursing home facility could not meet. The documentation did not show the specific services the receiving facility would provide to meet the needs of the resident which could not be met at the nursing home facility for Resident #1.

During an interview on 11/9/2020 at 2:53 PM, the Social Worker (SW) #1
confirmed Resident #1 was easily upset and at other times exhibited very unpredictable behaviors.

During an interview on 11/10/2020 at 9:33 AM, Nurse Manager #1 confirmed Resident #1 was anxious, combative, verbally abusive, yelled, exhibited exit seeking behavior, and hit on the doors to exit the unit. The Nurse Manager stated, "...She (Resident #1) was unsafe to be here..." The Nurse Manager was a member of the Interdisciplinary Team which met frequently to review Resident #1 behaviors. The Nurse

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Manager stated, "...Her behavior did not improve after Geri-psych stay..."

During an interview on 11/10/2020 at 10:28 AM, Registered Nurse (RN) #1 confirmed she went to the Geri-Psych facility to assess Resident #1 for readmission to the nursing home on 3/23/2020. Resident #1 was screaming, cursing, and hitting the walls while walking down the hall. RN #1 requested the inpatient Geri-psych staff redirect Resident #1's behaviors. Upon the completion of Resident #1's assessment for readmission the resident was observed hitting and kicking as she exited down the hall in the Geri-Psych facility. RN #1 informed the inpatient Geri-Psych facility the nursing home could not meet the resident's needs and Resident #1 was too aggressive. The RN stated, "...There was no where we could place her where the patients would be safe..." The interview confirmed the RN informed the Director of Nursing verbally of her assessment of Resident #1.

During an interview on 11/10/2020 at 1:41 PM, Licensed Practical Nurse (LPN) #1 confirmed Resident #1 exhibited a lot of exit seeking behavior. LPN #1 stated, "...This place was not safe for her. She needed higher care we could not provide..."

During an interview on 11/12/2020 at 10:25 AM, the Director of Nursing (DON) confirmed on 3/23/2020 the facility was unable to meet Resident #1's needs and could not take the resident back. The DON stated, "...We did not take the resident back due to safety concerns. The resident was exiting seeking, and aggressive. We were concerned she would be aggressive with other residents..." Interview

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confirmed there was no physician documentation in Resident #1's medical record of the specific resident needs the nursing home could not meet. The DON confirmed there was no documentation in the resident's chart of the specific service the receiving facility would provide to meet the needs of Resident #1 which could not be met at the nursing home facility.

During a telephone interview on 11/12/2020 at 12:17 PM, the Medical Director stated, "...There are some resident's behavior we can't get under control and require acute psych services. When she became aggressive and a danger to staff and other residents we have to think of the safety and acute concerns..." The Medical Director confirmed she was unaware she had to document the specific resident needs the facility could not meet in the resident's chart or the specific service the receiving facility could provide to meet the resident's needs. The Medical Director stated, "...I would have expected the Nurse Practitioner to have documented in the chart..."

During an interview on 11/13/2020 at 12:05 PM, the Administrator confirmed the Interdisciplinary Team met often regarding Resident #1. The Administrator stated "...We were going to take her back. The Nurse Manager went to reevaluate the resident and she was still aggressive and was exit seeking when they brought her upfront for reevaluation. We could not take her back due to aggression. I was afraid to put other residents at risk because she would likely go after them when upset..." The Administrator confirmed the Physician failed to document the specific resident needs the nursing home facility could not meet for Resident #1. Continued interview confirmed the

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F 622	Continued From page 8 Physician failed to document in the resident's medical record the specific service the receiving facility would provide to meet the needs of the resident which could not be met at the nursing home facility.	F 622		